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Minority Report to the Massachusetts Health Care Task Force

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INTRODUCTION

I'm grateful to Professor Stuart Altman and Judge Herbert Wilkins, co-chairs of the Task Force, for allowing me to present this brief minority report to you.

The majority report lists the arguments for greater state responsibility for tackling health care problems. But that report generally rejects enlarging government's role beyond more measuring, monitoring, and reporting.

I think that position is mistaken. It relies too heavily on market forces that are unreliable in health care, and gives too much weight to what seems politically acceptable today.

Two years and 24 days ago, our state was shocked by the Harvard – Pilgrim receivership.

Early this month, many were surprised by the size of the problems facing the Beth Israel – Deaconess.

Health care is too vital to depend heavily on luck and last-minute rescues. State government can't keep waiting passively for the phone to ring.

Talented and dedicated elected officials and state workers are looking at aspects of health problems, but no one has the time, budget, or mission to systematically assess looming problems, their causes, and solutions.

This year, we will spend $45 billion on Massachusetts health care—$123 million daily—or double the state budget. Unless state government gets a better grip on health care, other parties will continue to define problems and demand more money to solve them.

With little free market competition in health care, the result of limited state action will be growing health care anarchy and many more bullets to dodge.

Three of the areas demanding state action are stabilizing needed hospitals, planning for contingencies, and advancing the public interest in affordable high-quality care for all.

1. Hospitals: Stabilizing all needed hospitals and paying them fairly.

Our state has lost half of the 140 acute hospitals open in 1960.

Surviving ERs face growing gridlock. As baby boomers age, we all face a shortage of staffed hospital beds. These are real problems. They deserve real solutions.

Instead, after years of justifying hospital closings, the Hospital Association has tried to use closings—and ER gridlock—to justify across-the-board Medicaid hikes. But hospitals with more money shut their ERs more often. And across-the-board Medicaid increases do little to help endangered hospitals. Instead, half of the money goes to the 20 most prosperous hospitals. And who benefits from higher state free care payments?

Real solutions for hospitals require the state to know more and do more:

- identifying which hospitals are needed
- regularly identifying which might close soon
- providing receivership, short-term cash, and management to save needed hospitals
- guaranteeing each needed hospital enough money to efficiently provide good care.

(Something similar should be done for nursing homes.)

Unless the state does these things, needed hospitals and ERs will continue to close—something that the commissioner of Public Health says is dangerous.

Last year, the Finance Working Group examined Everett's Whidden Hospital. We urged that it be saved, but had no tools to do so. Luckily, Cambridge Health Alliance stepped in.

This year, Waltham Hospital is about to close, and state government does not know if it is needed or how to save it. The persisting lack of information on need is cited by some as a reason for rejecting state intervention.

There's another view. Since half of our hospitals have closed, shouldn't those who'd allow another threatened hospital to close be obliged to prove that it is ***not*** needed?

Each threatened closing seems to be a surprise. Chapter 141 hearings mean very little in practice. The state needs information, tools, and authority to save needed care.

Preserving care is one reason for state government to act. Another is that, as hospitals close and merge, the survivors win greater bargaining power and even regional monopolies. State action to re-regulate hospital payment is the only effective way to put a ceiling or cap on hospitals' revenue.

It also can put a floor under hospital revenue, to make sure that each needed hospital gets enough money to remain open.

Without state action, powerful hospitals get more money, and weaker hospitals close—even when needed and less costly. To avoid rewarding and reinforcing the drift of care into more expensive hospitals, the state should track how it spends its scarce dollars.

2. Contingency planning

Health spending per person in Massachusetts is 30 percent above the U.S. average—an excess of $9 billion this year.

Still, financial margins or incomes of hospitals, nursing homes, physicians, home health agencies, and other caregivers average well below those in other states.

But it would cost $2 billion this year alone to bring them up to the profits or incomes prevailing nationally. And that would be a recurring cost.

Who would pay? Family health insurance premiums in Boston rose 50 percent in the past four years. Families' insurance costs are rising by 24 percent this year alone.

More money for health care means less money for everything else. That's obvious but it needs to be said often because our state has the world's costliest health care.

I think that the majority report is wrong to rely mainly on a combination of more money for business as usual and on market forces to remedy health care's ills.

First, that costs too much. A passive government lets interested parties politically define both problems and solutions, leaving the state to throw more money into health care, see patients suffer, or watch caregivers go broke. And leaving the state to be blamed.

Second, what if market forces plus more money for business as usual fail us? The state has no back-up plan to stabilize caregivers, to hold down costs, or to protect access and quality. It needs to work with caregivers, payors, and advocates to develop those plans.

Now is the time to do that—before a crisis hits. The cost of preparation is far smaller than the financial and human cost of coping unprepared with meltdown. With health spending here running at $85,000 per minute, it might require around 23 minutes out of the yearly total—up to two million dollars a year—to finance contingency planning.

State government needs to pull together a small but permanent health finance strategy group of state employees and others. Obtaining the most accurate and most current data and analysis available, the group should have two jobs.

The first is to identify specific threats, such as the bankruptcy of a dozen more hospitals and dozens more nursing homes, skyrocketing insurance premiums, soaring drug costs, or a doubling of the number of people without health insurance (which actually happened from 1987 to 1994), and to identify and analyze specific responses by state government, caregivers, and payors. For example, a state receivership law for HMOs was vital to help stabilize Harvard-Pilgrim. But we lack any such tool for hospital preservation.

The second job is to weave the solutions to the specific threats into a durably affordable fabric. It is vital to investigate the many causes of high health costs here, and what can be done to lower them while protecting coverage, caregivers, and quality. That protection requires practical steps to move care into lower-cost settings. And it must

include practical ways to deeply cut administrative and clinical waste. It should empower physicians to spend money ever-more-carefully—in ways we can trust.

3. One hand for yourself and one hand for the ship.

Contingency planning alone will help us get ready. But without a new outlook on health care—without a greater commitment by all stakeholders to durably affordable and high-quality care for all—even the best planning and preparation will be too little and too late to protect us all from medical meltdown.

For understandable reasons, each stakeholder in Massachusetts health care fights for its own interests. Caregivers seek more money. Each payor tries to pay less or to shift costs to another payor.

In the free market economy, the rule is, "Both hands for yourself, and preferably in someone else's pocket." In a genuine free market, Adam Smith's invisible hand converts private greed and naked self-interest into the public good.

In health care, self-interested actions do not yield anything close to the public good. That's because health care doesn't and can't have anything close to a free market.

When the market fails in health care, the alternative to a greater government role is medical meltdown and anarchy. A greater public role is unattractive to many, and it will be very hard, but there's no choice. Politics is all we have left after economics fails.

Happily, the $45 billion to be spent on health care in this state, this year—over $7,000 per person—should be enough to deliver the care that works to all of us who need it.

To make this real, we should all dedicate ourselves to spending money better. Since state government represents the public interest, it must take the lead—by rejecting and exposing unreasonably self-interested claims, and by demanding that each stakeholder consider needs of others. Each stakeholder must think of itself in part as a trustee for the health of all who live here. That's not pious moralizing. It's essential to prevent the meltdown that will cripple each stakeholder. And it will calm the political waters through which state government will have to steer health care.

As sailors say, "One hand for yourself and one for the ship."

There is another old saying. "If I am not for myself, who will be for me? But if I am for myself alone, what am I?"